

1837

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BELAIR				c. LENGTH OF STAY IN 1b 4 Mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X1 RURAL JOPPA.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 302 S. MAIN ST.				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BLANCHE McCULLOUGH ANDERSON				4. DATE OF DEATH 2-24-1957			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-27-1875	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) W. VA.	
12. CITIZEN OF WHAT COUNTRY? USA.							
13. FATHER'S NAME MR WILLIAM H. McCULLOUGH				14. MOTHER'S MAIDEN NAME SARA ROCKWELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Harry W. Orshum		Address Bel Air Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of liver 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 year??	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11 Dec , 19 57 , to 24 Feb , 19 57 , that I last saw the deceased alive on 21 Feb , 19 57 , and that death occurred at 8 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles Richardson M.D.				ADDRESS (Street, city or town, state) Bel Air Md		DATE SIGNED 25 Feb 57	
PHYSICIAN'S NAME (Type) Charles Richardson				Bel Air, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-27-1957		22c. NAME OF CEMETERY OR CREMATORY Mountain Crest		22d. LOCATION (City, town, or county) (State) Joppa, Harford Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth W. Orshum				ADDRESS Stevardstown Pa.		24a. REC'D BY REGISTRAR 2-26-57	
				24b. REGISTRAR'S SIGNATURE Priscilla Lowmyer			

THE LOW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 24 HOURS AFTER DEATH. PAGE 4 MAY BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN. TO FUNERAL DIRECTOR: AFTER THIS CERTIFICATE HAS BEEN SIGNED BY THE ATTENDING PHYSICIAN AND COMPLETELY FILLED IN BY THE FUNERAL DIRECTOR, PAGE 3 SHOULD BE DETACHED FOR USE AS THE BURIAL-TRANSIT PERMIT. THEN PLEASE REMOVE CARBON PAPERS. PAGES 1 AND 2 SHOULD BE FILED WITH THE REGISTRAR PRIOR TO BURIAL, CREMATION, OR REMOVAL, AND IN ANY EVENT WITHIN 72 HOURS AFTER DEATH.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MOBILE, ALABAMA	
MARRIAGE		DATE		PLACE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		1945		MEMPHIS, TENN.		JANET RAY		4/4/68		MEMPHIS, TENN.	
OCCUPATION		DATE		PLACE		NAME OF EMPLOYER		DATE OF DEATH		PLACE OF DEATH	
CONTRACTOR		1967		MEMPHIS, TENN.		FEDERAL BUREAU OF INVESTIGATION		4/4/68		MEMPHIS, TENN.	
EDUCATION		DATE		PLACE		NAME OF SCHOOL		DATE OF DEATH		PLACE OF DEATH	
HIGH SCHOOL		1940		MEMPHIS, TENN.		MEMPHIS HIGH SCHOOL		4/4/68		MEMPHIS, TENN.	
RELIGION		DATE		PLACE		NAME OF CHURCH		DATE OF DEATH		PLACE OF DEATH	
METHODIST		1945		MEMPHIS, TENN.		METHODIST CHURCH		4/4/68		MEMPHIS, TENN.	
CAUSE OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		1968		MEMPHIS, TENN.		JAMES EARL RAY		4/4/68		MEMPHIS, TENN.	
MANNER OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
NATURAL		1968		MEMPHIS, TENN.		JAMES EARL RAY		4/4/68		MEMPHIS, TENN.	
PLACE OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
MEMPHIS, TENN.		1968		MEMPHIS, TENN.		JAMES EARL RAY		4/4/68		MEMPHIS, TENN.	
NAME OF PHYSICIAN		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		1968		MEMPHIS, TENN.		JAMES EARL RAY		4/4/68		MEMPHIS, TENN.	
NAME OF PHYSICIAN		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		1968		MEMPHIS, TENN.		JAMES EARL RAY		4/4/68		MEMPHIS, TENN.	

BUREAU V. S.

FEB 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01852

1838

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE		c. LENGTH OF STAY IN 1b 15 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 ABERDEEN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.				d. STREET ADDRESS 145 BRANNAN Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LAWRENCE Middle E Last BAUER				4. DATE OF DEATH Month FEBRUARY Day 28 Year 19 57			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 23, 1887	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME W. William				14. MOTHER'S MAIDEN NAME MARY K. FRENCH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 220-220219		17. INFORMANT Address Mary Ford Bauer, 145 Brannan Rd. Aberdeen MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior Coronary Thrombosis with myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 15 days ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gangrene of left foot due to peripheral arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —					
20c. TIME OF DEATH Hour o. m. p. m. — 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from Feb. 17th , 19 57 , to Feb. 28th , 19 57 , that I last saw the deceased alive on 2/28th , 19 57 , and that death occurred at 6:30 M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward C. Loo, M.D.		M.D.		ADDRESS (Street, city or town, state) 211 North Union Ave. Havre de Grace, Md.		DATE SIGNED Feb. 28th 57	
PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.		22b. DATE THEREOF 3-2-57		22c. NAME OF CEMETERY OR CREMATORY ANGEL HILL		22d. LOCATION (City, town, or county) (State) HAVRE DE GRACE MD	
23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell		ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR —		24b. REGISTRAR'S SIGNATURE G. J. Dennis M.D.	

CERTIFICATE OF DEATH

MD 10-1-15

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]	
4. PLACE OF BIRTH [Faint text]		5. DATE OF BIRTH [Faint text]		6. PLACE OF DEATH [Faint text]	
7. OCCUPATION [Faint text]		8. CAUSE OF DEATH [Faint text]		9. MANNER OF DEATH [Faint text]	
10. SIGNATURE OF PHYSICIAN [Faint text]		11. SIGNATURE OF CORONER [Faint text]		12. SIGNATURE OF DECEASED [Faint text]	
13. SIGNATURE OF WITNESS [Faint text]		14. SIGNATURE OF DECEASED [Faint text]		15. SIGNATURE OF DECEASED [Faint text]	
16. SIGNATURE OF DECEASED [Faint text]		17. SIGNATURE OF DECEASED [Faint text]		18. SIGNATURE OF DECEASED [Faint text]	
19. SIGNATURE OF DECEASED [Faint text]		20. SIGNATURE OF DECEASED [Faint text]		21. SIGNATURE OF DECEASED [Faint text]	
22. SIGNATURE OF DECEASED [Faint text]		23. SIGNATURE OF DECEASED [Faint text]		24. SIGNATURE OF DECEASED [Faint text]	
25. SIGNATURE OF DECEASED [Faint text]		26. SIGNATURE OF DECEASED [Faint text]		27. SIGNATURE OF DECEASED [Faint text]	
28. SIGNATURE OF DECEASED [Faint text]		29. SIGNATURE OF DECEASED [Faint text]		30. SIGNATURE OF DECEASED [Faint text]	
31. SIGNATURE OF DECEASED [Faint text]		32. SIGNATURE OF DECEASED [Faint text]		33. SIGNATURE OF DECEASED [Faint text]	
34. SIGNATURE OF DECEASED [Faint text]		35. SIGNATURE OF DECEASED [Faint text]		36. SIGNATURE OF DECEASED [Faint text]	
37. SIGNATURE OF DECEASED [Faint text]		38. SIGNATURE OF DECEASED [Faint text]		39. SIGNATURE OF DECEASED [Faint text]	
40. SIGNATURE OF DECEASED [Faint text]		41. SIGNATURE OF DECEASED [Faint text]		42. SIGNATURE OF DECEASED [Faint text]	
43. SIGNATURE OF DECEASED [Faint text]		44. SIGNATURE OF DECEASED [Faint text]		45. SIGNATURE OF DECEASED [Faint text]	
46. SIGNATURE OF DECEASED [Faint text]		47. SIGNATURE OF DECEASED [Faint text]		48. SIGNATURE OF DECEASED [Faint text]	
49. SIGNATURE OF DECEASED [Faint text]		50. SIGNATURE OF DECEASED [Faint text]		51. SIGNATURE OF DECEASED [Faint text]	
52. SIGNATURE OF DECEASED [Faint text]		53. SIGNATURE OF DECEASED [Faint text]		54. SIGNATURE OF DECEASED [Faint text]	
55. SIGNATURE OF DECEASED [Faint text]		56. SIGNATURE OF DECEASED [Faint text]		57. SIGNATURE OF DECEASED [Faint text]	
58. SIGNATURE OF DECEASED [Faint text]		59. SIGNATURE OF DECEASED [Faint text]		60. SIGNATURE OF DECEASED [Faint text]	
61. SIGNATURE OF DECEASED [Faint text]		62. SIGNATURE OF DECEASED [Faint text]		63. SIGNATURE OF DECEASED [Faint text]	
64. SIGNATURE OF DECEASED [Faint text]		65. SIGNATURE OF DECEASED [Faint text]		66. SIGNATURE OF DECEASED [Faint text]	
67. SIGNATURE OF DECEASED [Faint text]		68. SIGNATURE OF DECEASED [Faint text]		69. SIGNATURE OF DECEASED [Faint text]	
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73. SIGNATURE OF DECEASED [Faint text]		74. SIGNATURE OF DECEASED [Faint text]		75. SIGNATURE OF DECEASED [Faint text]	
76. SIGNATURE OF DECEASED [Faint text]		77. SIGNATURE OF DECEASED [Faint text]		78. SIGNATURE OF DECEASED [Faint text]	
79. SIGNATURE OF DECEASED [Faint text]		80. SIGNATURE OF DECEASED [Faint text]		81. SIGNATURE OF DECEASED [Faint text]	
82. SIGNATURE OF DECEASED [Faint text]		83. SIGNATURE OF DECEASED [Faint text]		84. SIGNATURE OF DECEASED [Faint text]	
85. SIGNATURE OF DECEASED [Faint text]		86. SIGNATURE OF DECEASED [Faint text]		87. SIGNATURE OF DECEASED [Faint text]	
88. SIGNATURE OF DECEASED [Faint text]		89. SIGNATURE OF DECEASED [Faint text]		90. SIGNATURE OF DECEASED [Faint text]	
91. SIGNATURE OF DECEASED [Faint text]		92. SIGNATURE OF DECEASED [Faint text]		93. SIGNATURE OF DECEASED [Faint text]	
94. SIGNATURE OF DECEASED [Faint text]		95. SIGNATURE OF DECEASED [Faint text]		96. SIGNATURE OF DECEASED [Faint text]	
97. SIGNATURE OF DECEASED [Faint text]		98. SIGNATURE OF DECEASED [Faint text]		99. SIGNATURE OF DECEASED [Faint text]	
100. SIGNATURE OF DECEASED [Faint text]		101. SIGNATURE OF DECEASED [Faint text]		102. SIGNATURE OF DECEASED [Faint text]	

BUREAU V. S.

MAR 4 1957

RECEIVED

1845 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federal Hill</u>		c. LENGTH OF STAY IN 1b <u>14 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federal Hill - Street Rd. 1</u> d. STREET ADDRESS <u>—</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Lee Beamer</u> First Middle Last		4. DATE OF DEATH <u>Feb</u> Month <u>8th</u> Day <u>1957</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 18 1876</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR: Months <u>9</u> Days <u>20</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Floyd Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Beamer</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Martin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Lila Beamer</u> Address <u>Street Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Rupture</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Myocardial infarction</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized atherosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5 Feb</u> , 19 <u>57</u> , to <u>8 Feb</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8 Feb</u> , 19 <u>57</u> , and that death occurred at <u>4:20 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Garrettsville, Md.</u> DATE SIGNED <u>—</u>			
ACTUAL SIGNATURE <u>Thos. A. Moseley</u> M.D. <u>Garrettsville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>—</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/12/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Long Green Brethren</u>	22d. LOCATION (City, town, or county) (State) <u>Long Green, Bath. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin J. Kurtz</u> ADDRESS <u>Garrettsville Md.</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>2-12-57</u>	24b. REGISTRAR'S SIGNATURE <u>Annelle Fowood</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Married - Alfred
Federal Hill - Street 12.1

Married
Federal Hill

Robert Lee Gerner
Male white
John Gerner
Lila Gerner Street 12.1
Elizabeth Gerner
Floyd Gerner
Gerner 12.1 St

BUREAU V. 31

23 14 1957

RECEIVED

Food given to them food given to them

Serial

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1839

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01854

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford de Grace</i>		c. LENGTH OF STAY IN 1b <i>11 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington 47X-3</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>		d. STREET ADDRESS <i>2130 13th St SE</i>	
3. NAME OF DECEASED (Type or print) <i>Charles Alvin Benjamin</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
4. DATE OF DEATH <i>February 21 1957</i>	5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>March 7, 1916</i>	9. AGE (In years last birthday) <i>40</i> yrs.	IF UNDER 1 YEAR Months <i>40</i> Days <i>0</i> Hours <i>0</i> Min.	IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck driver</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Chesapeake Motors</i>	
11. BIRTHPLACE (State or foreign country) <i>Harifax, Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>CHARLES BENJAMINI</i>		14. MOTHER'S MAIDEN NAME <i>BESSIE HAVENIER</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i> (If yes, give war or dates of service) <i>W.W. II</i>		16. SOCIAL SECURITY NO. <i>825X</i>	
17. INFORMANT <i>Mrs Eunice M. Benjamin</i>		Address <i>2130 13th St SE Wash. D.C.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture skull</i> DUE TO <i>825X</i> Conditions, if any, which gave rise to immediate cause (b) <i>825X</i> (a), stating the underlying cause first. DUE TO (c) <i>825X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>11 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Fracture both bones both legs</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <i>Anto accident</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <i>2-10-57</i> Hour <i>3</i> o. m. <i>3</i> a. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>US Route 1</i>		20f. (City or town) <i>Bel Air Harford Md.</i> (County) <i>Harford</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Gerald C Palmer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Harford County</i> DATE SIGNED <i>2-21-57</i>	
EXAMINER'S NAME (Type) <i>Gerald C Palmer</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-25-1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Washington National</i>		22d. LOCATION (City, town, or county) <i>ARLINGTON VIRGINIA</i> (State) <i>VA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers & Co. Washington, D.C.</i>		24a. REC'D BY REGISTRAR <i>DATE 25 1957</i>	
		24b. REGISTRAR'S SIGNATURE <i>R. L. Lewis</i>	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED SEX AGE DATE OF BIRTH PLACE OF BIRTH OCCUPATION MARITAL STATUS COLOR RELIGION EDUCATION SOCIAL SECURITY NUMBER MOTHER'S MARRIAGE LICENSE NUMBER MOTHER'S BIRTH DATE MOTHER'S PLACE OF BIRTH MOTHER'S OCCUPATION MOTHER'S MARITAL STATUS MOTHER'S COLOR MOTHER'S RELIGION MOTHER'S EDUCATION MOTHER'S SOCIAL SECURITY NUMBER MOTHER'S MARRIAGE LICENSE NUMBER MOTHER'S BIRTH DATE MOTHER'S PLACE OF BIRTH MOTHER'S OCCUPATION MOTHER'S MARITAL STATUS MOTHER'S COLOR MOTHER'S RELIGION MOTHER'S EDUCATION MOTHER'S SOCIAL SECURITY NUMBER		DATE OF DEATH TIME OF DEATH PLACE OF DEATH CAUSE OF DEATH MANNER OF DEATH MEDICAL HISTORY PRESENT ILLNESS TREATMENT POSTMORTEM EXAMINATION FINDINGS CONCLUSIONS SIGNATURE OF EXAMINER DATE OF SIGNATURE PLACE OF SIGNATURE TITLE OF EXAMINER BOARD OF HEALTH COUNTY OF STATE OF	
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BUREAU V. 3

FEB 25 1957

RECEIVED

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county)	(State)
Normal	2/13/57	Brooks	Warrenville	N. C.
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Emmington & M. Hardee, Inc.	M.D.		DATE 2-11-57	G. L. Hewitt M.

2071234 XV 3

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

PLACE ON FRONT		MARRIAGE	
DATE OF DEATH		PLACE OF DEATH	
AGE		SEX	
RACE		EDUCATION	
OCCUPATION		MILITARY SERVICE	
CAUSE OF DEATH		MANNER OF DEATH	
DATE OF BURIAL		PLACE OF BURIAL	
SIGNATURE OF REGISTRAR		SIGNATURE OF DECEASED	
DATE OF REGISTRATION		PLACE OF REGISTRATION	
FEE		REMARKS	

RECEIVED
 FEB 13 1957
 BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1841

CERTIFICATE OF DEATH

0185561

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen (Rural)</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Aberdeen Rural</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Churchville</i>		d. STREET ADDRESS <i>1 Churchville</i>	
3. NAME OF DECEASED (Type or print) First <i>Fluie</i> Middle <i>Elvina</i> Last <i>Chesney</i>		4. DATE OF DEATH Month <i>Feb</i> Day <i>18th</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/26/1879</i>
9. AGE (In years last birthday) <i>77</i> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>John Thomas Mitchell</i>	
14. MOTHER'S MAIDEN NAME <i>Eliza Bruce</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Address <i>#2 Mrs Richard R. Wilson Aberdeen Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIO-RESPIRATORY FAILURE</i> <i>550.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>COMPLICATIONS OF RUPTURED APPENDIX</i> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <i>24 HOURS</i> <i>2 1/2 YEARS.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>PERITONEAL EFFUSION</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <i>MARCH</i> , 19 <i>53</i> , to <i>18 FEB</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>18 FEB</i> , 19 <i>57</i> , and that death occurred at <i>9:20 P.</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H. P. Sidwell</i>		ADDRESS (Street, city or town, state) <i>Bel Air Md.</i>	
PHYSICIAN'S NAME (Type) <i>H. P. SIDWELL M.D.</i>		DATE SIGNED <i>1956 57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2/21/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Palmy Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Bel Air R.T. Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Garring</i>		ADDRESS <i>Aberdeen, Maryland</i>	
24a. REC'D BY REGISTRAR <i>Feb 21-57</i>		24b. REGISTRAR'S SIGNATURE <i>Nellie K. Perry</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF DEATH</p>	
<p>5. PLACE OF DEATH</p>		<p>6. CAUSE OF DEATH</p>	
<p>7. PLACE OF BIRTH</p>		<p>8. OCCUPATION</p>	
<p>9. MARITAL STATUS</p>		<p>10. EDUCATION</p>	
<p>11. RELIGION</p>		<p>12. RACE</p>	
<p>13. DATE OF BIRTH</p>		<p>14. DATE OF DEATH</p>	
<p>15. PLACE OF BIRTH</p>		<p>16. PLACE OF DEATH</p>	
<p>17. CAUSE OF DEATH</p>		<p>18. PLACE OF BIRTH</p>	
<p>19. PLACE OF DEATH</p>		<p>20. CAUSE OF DEATH</p>	
<p>21. PLACE OF BIRTH</p>		<p>22. PLACE OF DEATH</p>	
<p>23. CAUSE OF DEATH</p>		<p>24. PLACE OF BIRTH</p>	
<p>25. PLACE OF DEATH</p>		<p>26. CAUSE OF DEATH</p>	
<p>27. PLACE OF BIRTH</p>		<p>28. PLACE OF DEATH</p>	
<p>29. CAUSE OF DEATH</p>		<p>30. PLACE OF BIRTH</p>	
<p>31. PLACE OF DEATH</p>		<p>32. CAUSE OF DEATH</p>	
<p>33. PLACE OF BIRTH</p>		<p>34. PLACE OF DEATH</p>	
<p>35. CAUSE OF DEATH</p>		<p>36. PLACE OF BIRTH</p>	
<p>37. PLACE OF DEATH</p>		<p>38. CAUSE OF DEATH</p>	
<p>39. PLACE OF BIRTH</p>		<p>40. PLACE OF DEATH</p>	
<p>41. CAUSE OF DEATH</p>		<p>42. PLACE OF BIRTH</p>	
<p>43. PLACE OF DEATH</p>		<p>44. CAUSE OF DEATH</p>	
<p>45. PLACE OF BIRTH</p>		<p>46. PLACE OF DEATH</p>	
<p>47. CAUSE OF DEATH</p>		<p>48. PLACE OF BIRTH</p>	
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<p>51. PLACE OF BIRTH</p>		<p>52. PLACE OF DEATH</p>	
<p>53. CAUSE OF DEATH</p>		<p>54. PLACE OF BIRTH</p>	
<p>55. PLACE OF DEATH</p>		<p>56. CAUSE OF DEATH</p>	
<p>57. PLACE OF BIRTH</p>		<p>58. PLACE OF DEATH</p>	
<p>59. CAUSE OF DEATH</p>		<p>60. PLACE OF BIRTH</p>	
<p>61. PLACE OF DEATH</p>		<p>62. CAUSE OF DEATH</p>	
<p>63. PLACE OF BIRTH</p>		<p>64. PLACE OF DEATH</p>	
<p>65. CAUSE OF DEATH</p>		<p>66. PLACE OF BIRTH</p>	
<p>67. PLACE OF DEATH</p>		<p>68. CAUSE OF DEATH</p>	
<p>69. PLACE OF BIRTH</p>		<p>70. PLACE OF DEATH</p>	
<p>71. CAUSE OF DEATH</p>		<p>72. PLACE OF BIRTH</p>	
<p>73. PLACE OF DEATH</p>		<p>74. CAUSE OF DEATH</p>	
<p>75. PLACE OF BIRTH</p>		<p>76. PLACE OF DEATH</p>	
<p>77. CAUSE OF DEATH</p>		<p>78. PLACE OF BIRTH</p>	
<p>79. PLACE OF DEATH</p>		<p>80. CAUSE OF DEATH</p>	
<p>81. PLACE OF BIRTH</p>		<p>82. PLACE OF DEATH</p>	
<p>83. CAUSE OF DEATH</p>		<p>84. PLACE OF BIRTH</p>	
<p>85. PLACE OF DEATH</p>		<p>86. CAUSE OF DEATH</p>	
<p>87. PLACE OF BIRTH</p>		<p>88. PLACE OF DEATH</p>	
<p>89. CAUSE OF DEATH</p>		<p>90. PLACE OF BIRTH</p>	
<p>91. PLACE OF DEATH</p>		<p>92. CAUSE OF DEATH</p>	
<p>93. PLACE OF BIRTH</p>		<p>94. PLACE OF DEATH</p>	
<p>95. CAUSE OF DEATH</p>		<p>96. PLACE OF BIRTH</p>	
<p>97. PLACE OF DEATH</p>		<p>98. CAUSE OF DEATH</p>	
<p>99. PLACE OF BIRTH</p>		<p>100. PLACE OF DEATH</p>	

BUREAU V. 2

FEB 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 0211 2-21-57 et

1842

CERTIFICATE OF DEATH

01857

Reg. Dist. No. 782

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belt Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Belt Air</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>230 Baltimore Ave</u>		d. STREET ADDRESS <u>1230 Baltimore Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Cohen</u> Last <u>Cohen</u>		4. DATE OF DEATH Month <u>February</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15/1888</u> 68 yrs.
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mountain Hardware Md</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>James E. Smith</u> Address <u>Bt 374</u>	
17. INFORMANT <u>James E. Smith</u> Address <u>Bt 374</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma pharynx</u> <u>148X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-5</u> , 19 <u>56</u> , to <u>2-7</u> , 19 <u>57</u> that I last saw the deceased alive on <u>2-6</u> , 19 <u>57</u> , and that death occurred at <u>104</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		ADDRESS (Street, city or town, state) <u>Belt Air, Md.</u> DATE SIGNED <u>2-7-57</u>	
PHYSICIAN'S NAME (Type) <u>Gerald C Palmer MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 9/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Clarks Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Kelvin Harbor Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Belar</u> ADDRESS <u>Md</u>		24a. REC'D BY REGISTRAR DATE <u>2-7-57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Priscilla Lowwood</u>	

BUREAU V. S.

FFB 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1843

CERTIFICATE OF DEATH

01858

Reg. Dist. No.

185

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sumner de Grace</u>				c. LENGTH OF STAY IN 1b <u>2 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>07822 Perryville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>Route 40</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Augustine</u> Middle <u>D.</u> Last <u>Coudon</u>				4. DATE OF DEATH Month <u>February</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-2-1901</u>	
9. AGE (In years lost birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Month <u>8</u> Days <u>4</u> Hours <u>13</u> Min.		IF UNDER 24 HRS. Month <u>8</u> Days <u>4</u> Hours <u>13</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Service Supervisor U.S.A.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Coudon</u>				14. MOTHER'S MAIDEN NAME <u>Clarita Walcott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Henry F. Coudon, Port Deposit, Md.</u> Address <u>PR 10</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardio Vascular</u> <u>420.1</u> DUE TO <u>Hypertensive Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Thrombosis</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>2/11</u> , 1957, to <u>2/13</u> , 1957, that I last saw the deceased alive on <u>2/13</u> , 1957, and that death occurred at <u>9:20</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles J. Foley</u> M.D.				ADDRESS (Street, city or town, state) <u>400 P. Main St. Perryville, Md.</u> DATE SIGNED <u>2/13/57</u>			
PHYSICIAN'S NAME (Type) <u>Charles J. Foley</u>				<u>HAROLD DE GRACE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2-16-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Old Bohemia Cem.</u>		22d. LOCATION (City, town, or county) <u>Warwick, Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lisa Patterson & Son</u> ADDRESS <u>Perryville, Md.</u>				24a. REC'D BY REGISTRAR <u>G. L. Lewis M.D.</u> DATE <u>2-17-57</u>		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. S.

FEB 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01859

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laure de Grace</u>		c. LENGTH OF STAY IN 1b <u>4 hours</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gerald</u> Middle <u>Deel</u> Last <u>Deel</u>		4. DATE OF DEATH Month <u>February</u> Day <u>10</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 7, 1937</u>
9. AGE (In years last birthday) <u>19</u> yrs.		10. IF UNDER 1 YEAR: Months <u>19</u> Days <u>19</u> Hours <u>19</u> Min. <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crane Follower</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>	
11. BIRTHPLACE (State or foreign country) <u>W.Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Arnold Deel</u>		14. MOTHER'S MAIDEN NAME <u>Anna R. Mc Fadden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>232-56-8483</u>	
17. INFORMANT Address <u>Mrs. Anna R. Deel, Joppa, Harford Co., Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>816X</u> (c) <u>816X</u> DUE TO cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture femur</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto-auto type</u>	
20c. TIME OF INJURY Month, Day, Year <u>2-10-57</u> Hour <u>2:20</u> o. m. <u>pm.</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bel Air Hospital</u>		20f. (City or town) <u>Bel Air</u> (County) <u>Harford</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Harford County</u>		DATE SIGNED <u>2-10-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 12, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		22d. LOCATION (City, town, or county) <u>Bel Air, Harford, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard L. McComas & Son</u>		ADDRESS <u>Abingdon Md.</u>	
24a. REC'D BY REGISTRAR <u>Feb. 13-57</u>		24b. REGISTRAR'S SIGNATURE <u>A. L. Dennis m.d.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. RELIGION		10. EDUCATION		11. SOCIAL STATUS		12. PRESENT ADDRESS	
13. PREVIOUS ADDRESS		14. DATE OF DEATH		15. TIME OF DEATH		16. PLACE OF DEATH	
17. CAUSE OF DEATH		18. MANNER OF DEATH		19. SIGNATURE OF EXAMINER		20. OFFICE OF EXAMINER	
21. SIGNATURE OF WITNESS		22. OFFICE OF WITNESS		23. SIGNATURE OF JURY		24. OFFICE OF JURY	
25. SIGNATURE OF CLERK		26. OFFICE OF CLERK		27. SIGNATURE OF DEPUTY CLERK		28. OFFICE OF DEPUTY CLERK	
29. SIGNATURE OF ASSISTANT CLERK		30. OFFICE OF ASSISTANT CLERK		31. SIGNATURE OF RECORDS CLERK		32. OFFICE OF RECORDS CLERK	
33. SIGNATURE OF CHIEF CLERK		34. OFFICE OF CHIEF CLERK		35. SIGNATURE OF DEPUTY CHIEF CLERK		36. OFFICE OF DEPUTY CHIEF CLERK	
37. SIGNATURE OF ASSISTANT CHIEF CLERK		38. OFFICE OF ASSISTANT CHIEF CLERK		39. SIGNATURE OF RECORDS ASSISTANT		40. OFFICE OF RECORDS ASSISTANT	
41. SIGNATURE OF CLERK		42. OFFICE OF CLERK		43. SIGNATURE OF DEPUTY CLERK		44. OFFICE OF DEPUTY CLERK	
45. SIGNATURE OF ASSISTANT CLERK		46. OFFICE OF ASSISTANT CLERK		47. SIGNATURE OF RECORDS CLERK		48. OFFICE OF RECORDS CLERK	
49. SIGNATURE OF CHIEF CLERK		50. OFFICE OF CHIEF CLERK		51. SIGNATURE OF DEPUTY CHIEF CLERK		52. OFFICE OF DEPUTY CHIEF CLERK	
53. SIGNATURE OF ASSISTANT CHIEF CLERK		54. OFFICE OF ASSISTANT CHIEF CLERK		55. SIGNATURE OF RECORDS CLERK		56. OFFICE OF RECORDS CLERK	
57. SIGNATURE OF CLERK		58. OFFICE OF CLERK		59. SIGNATURE OF DEPUTY CLERK		60. OFFICE OF DEPUTY CLERK	
61. SIGNATURE OF ASSISTANT CLERK		62. OFFICE OF ASSISTANT CLERK		63. SIGNATURE OF RECORDS CLERK		64. OFFICE OF RECORDS CLERK	
65. SIGNATURE OF CHIEF CLERK		66. OFFICE OF CHIEF CLERK		67. SIGNATURE OF DEPUTY CHIEF CLERK		68. OFFICE OF DEPUTY CHIEF CLERK	
69. SIGNATURE OF ASSISTANT CHIEF CLERK		70. OFFICE OF ASSISTANT CHIEF CLERK		71. SIGNATURE OF RECORDS CLERK		72. OFFICE OF RECORDS CLERK	
73. SIGNATURE OF CLERK		74. OFFICE OF CLERK		75. SIGNATURE OF DEPUTY CLERK		76. OFFICE OF DEPUTY CLERK	
77. SIGNATURE OF ASSISTANT CLERK		78. OFFICE OF ASSISTANT CLERK		79. SIGNATURE OF RECORDS CLERK		80. OFFICE OF RECORDS CLERK	
81. SIGNATURE OF CHIEF CLERK		82. OFFICE OF CHIEF CLERK		83. SIGNATURE OF DEPUTY CHIEF CLERK		84. OFFICE OF DEPUTY CHIEF CLERK	
85. SIGNATURE OF ASSISTANT CHIEF CLERK		86. OFFICE OF ASSISTANT CHIEF CLERK		87. SIGNATURE OF RECORDS CLERK		88. OFFICE OF RECORDS CLERK	
89. SIGNATURE OF CLERK		90. OFFICE OF CLERK		91. SIGNATURE OF DEPUTY CLERK		92. OFFICE OF DEPUTY CLERK	
93. SIGNATURE OF ASSISTANT CLERK		94. OFFICE OF ASSISTANT CLERK		95. SIGNATURE OF RECORDS CLERK		96. OFFICE OF RECORDS CLERK	
97. SIGNATURE OF CHIEF CLERK		98. OFFICE OF CHIEF CLERK		99. SIGNATURE OF DEPUTY CHIEF CLERK		100. OFFICE OF DEPUTY CHIEF CLERK	

BUREAU V. 2

FEB 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18&20 Film 211-7-1-57 and Item 8 Film G212 3-11-57 et

CERTIFICATE OF DEATH

01860

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLORA 07X02</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL Hosp.</u>		d. STREET ADDRESS <u>RFD #1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY JANE DIASMORE</u>		4. DATE OF DEATH Month Day Year <u>FEBRUARY 28 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/1/1889</u>
9. AGE (In years last birthday) yrs. <u>78</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas KRAUSS</u>		14. MOTHER'S MAIDEN NAME <u>MARY SWIFT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>		17. INFORMANT Address <u>Mary Finnefrock, Rising Sun md</u>	
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Left Femur</u> <u>422.1</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> (b) <u>Arteriosclerotic Cardiovascular Disease</u> (c) <u>Arteriosclerotic Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>904.0 Fracture left femur</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>11-24-56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Colora, RD #1 Md</u>	
21. I certify that I attended the deceased from <u>11/26</u> , 19 <u>57</u> , to <u>Feb 28, 1957</u> , that I last saw the deceased alive on <u>Feb 28</u> , 19 <u>57</u> , and that death occurred at <u>4:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles J. Foley</u> M.D.		DATE SIGNED <u>3/1/57</u>	
PHYSICIAN'S NAME (Type) <u>CHARLES J. FOLEY</u>		ADDRESS (Street, city or town, state) <u>HAURE DE GRACE MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/4/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brookview</u>		22d. LOCATION (City, town or county) (State) <u>Rising Sun Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M Reed</u>		24a. REC'D BY REGISTRAR <u>Mar. 3-57</u>	
ADDRESS <u>Rising Sun, md</u>		24b. REGISTRAR'S SIGNATURE <u>G. D. Lewis</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 2

MAR 5 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01861

Reg. Dist. No. 180

1847

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY OR TOWN <u>Edgewood R.D.</u>		LENGTH OF STAY (In this place) <u>20 yrs.,</u>		CITY OR TOWN <u>Edgewood R.D.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>Van Bibber</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MARY</u> (Middle) <u>ELIZABETH</u> (Last) <u>GIBSON</u>				(Month) <u>Feb.</u> (Day) <u>13</u> (Year) <u>19 57</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Jan. 14, 1873</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Dodson</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Wolford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs. M.S. Meadows, Edgewood R.D. Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>CONGESTIVE HEART FAILURE</u>				<u>2 WEEKS</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>MILD DIABETES MELLITUS</u>				<u>UNKNOWN; AT LEAST 5 YEARS</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>1 YEAR</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JUNE</u> , 19 <u>56</u> , to <u>13 FEB.</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8 FEB.</u> , 19 <u>57</u> , and that death occurred at <u>3:15 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M.D. <u>BOX 95, EDGEWOOD, MD.</u>		DATE SIGNED <u>2/13/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 17, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Cokesbury Memorial</u>		LOCATION (City, town, or county) (State) <u>Abingdon, Harford, Md.</u>	
24. REC'D BY REGISTRAR <u>Feb. 18, 1957</u>		REGISTRAR'S SIGNATURE <u>Norma G. Moore</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. Thomas & Son</u> ADDRESS <u>Abingdon, Md.</u>			

CERTIFICATE OF DEATH

For Use No.

2. I hereby certify that the above is a true and correct copy of the original as filed in my office.

3. I hereby certify that the above is a true and correct copy of the original as filed in my office.

<p>1. Name of deceased: _____</p>		<p>4. Date of death: _____</p>	
<p>5. Place of death: _____</p>		<p>6. Cause of death: _____</p>	
<p>7. Name of physician: _____</p>		<p>8. Name of funeral home: _____</p>	
<p>9. Name of next of kin: _____</p>		<p>10. Name of informant: _____</p>	
<p>11. Name of registrar: _____</p>		<p>12. Name of registrar: _____</p>	
<p>13. Name of registrar: _____</p>		<p>14. Name of registrar: _____</p>	
<p>15. Name of registrar: _____</p>		<p>16. Name of registrar: _____</p>	
<p>17. Name of registrar: _____</p>		<p>18. Name of registrar: _____</p>	
<p>19. Name of registrar: _____</p>		<p>20. Name of registrar: _____</p>	
<p>21. Name of registrar: _____</p>		<p>22. Name of registrar: _____</p>	
<p>23. Name of registrar: _____</p>		<p>24. Name of registrar: _____</p>	
<p>25. Name of registrar: _____</p>		<p>26. Name of registrar: _____</p>	
<p>27. Name of registrar: _____</p>		<p>28. Name of registrar: _____</p>	
<p>29. Name of registrar: _____</p>		<p>30. Name of registrar: _____</p>	
<p>31. Name of registrar: _____</p>		<p>32. Name of registrar: _____</p>	
<p>33. Name of registrar: _____</p>		<p>34. Name of registrar: _____</p>	
<p>35. Name of registrar: _____</p>		<p>36. Name of registrar: _____</p>	
<p>37. Name of registrar: _____</p>		<p>38. Name of registrar: _____</p>	
<p>39. Name of registrar: _____</p>		<p>40. Name of registrar: _____</p>	
<p>41. Name of registrar: _____</p>		<p>42. Name of registrar: _____</p>	
<p>43. Name of registrar: _____</p>		<p>44. Name of registrar: _____</p>	
<p>45. Name of registrar: _____</p>		<p>46. Name of registrar: _____</p>	
<p>47. Name of registrar: _____</p>		<p>48. Name of registrar: _____</p>	
<p>49. Name of registrar: _____</p>		<p>50. Name of registrar: _____</p>	
<p>51. Name of registrar: _____</p>		<p>52. Name of registrar: _____</p>	
<p>53. Name of registrar: _____</p>		<p>54. Name of registrar: _____</p>	
<p>55. Name of registrar: _____</p>		<p>56. Name of registrar: _____</p>	
<p>57. Name of registrar: _____</p>		<p>58. Name of registrar: _____</p>	
<p>59. Name of registrar: _____</p>		<p>60. Name of registrar: _____</p>	
<p>61. Name of registrar: _____</p>		<p>62. Name of registrar: _____</p>	
<p>63. Name of registrar: _____</p>		<p>64. Name of registrar: _____</p>	
<p>65. Name of registrar: _____</p>		<p>66. Name of registrar: _____</p>	
<p>67. Name of registrar: _____</p>		<p>68. Name of registrar: _____</p>	
<p>69. Name of registrar: _____</p>		<p>70. Name of registrar: _____</p>	
<p>71. Name of registrar: _____</p>		<p>72. Name of registrar: _____</p>	
<p>73. Name of registrar: _____</p>		<p>74. Name of registrar: _____</p>	
<p>75. Name of registrar: _____</p>		<p>76. Name of registrar: _____</p>	
<p>77. Name of registrar: _____</p>		<p>78. Name of registrar: _____</p>	
<p>79. Name of registrar: _____</p>		<p>80. Name of registrar: _____</p>	
<p>81. Name of registrar: _____</p>		<p>82. Name of registrar: _____</p>	
<p>83. Name of registrar: _____</p>		<p>84. Name of registrar: _____</p>	
<p>85. Name of registrar: _____</p>		<p>86. Name of registrar: _____</p>	
<p>87. Name of registrar: _____</p>		<p>88. Name of registrar: _____</p>	
<p>89. Name of registrar: _____</p>		<p>90. Name of registrar: _____</p>	
<p>91. Name of registrar: _____</p>		<p>92. Name of registrar: _____</p>	
<p>93. Name of registrar: _____</p>		<p>94. Name of registrar: _____</p>	
<p>95. Name of registrar: _____</p>		<p>96. Name of registrar: _____</p>	
<p>97. Name of registrar: _____</p>		<p>98. Name of registrar: _____</p>	
<p>99. Name of registrar: _____</p>		<p>100. Name of registrar: _____</p>	

BUREAU V. B.

FEB 20 1957

RECEIVED

ENCLOSURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01862

1848

CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre De Grace		c. LENGTH OF STAY IN 1b 2 Weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point 07X02	
3. NAME OF DECEASED (Type or print) First Mary Middle Ann Last Gore		4. DATE OF DEATH Month 2 Day 5 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-24-1881
9. AGE (In years last birthday) 75		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Wisconsin	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Donovan		14. MOTHER'S MAIDEN NAME Brigitta Hackett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT Bdlg. 29B, Appt. 12, Mrs Robert Duffey, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular Failure - Uremia 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Conestive Heart Failure DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH Jan. 22. 57 to Feb. 5. 57	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 22 , 19 57 , to Feb. 5 , 19 57 , that I last saw the deceased alive on Feb. 5 , 19 57 , and that death occurred at 9:10 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Evelyn D. Hing		ADDRESS (Street, city or town, state) DATE SIGNED 421 Congress Ave. HAVRE DE GRACE, Md. 2-5-57	
PHYSICIAN'S NAME (Type) RUNTER D. HIRSCH		421 Congress Ave - Havre de Grace, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-8-1957	
22c. NAME OF CEMETERY OR CREMATORY St. Marks Cemetery		22d. LOCATION (City, town, or county) (State) Prescott, Ontario, Canada	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson + Son		ADDRESS Perryville, Md	
24a. REC'D BY REGISTRAR DATE 2-6-57		24b. REGISTRAR'S SIGNATURE G. L. Lewis m. l.	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Date of filing	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01863

181

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Abertdeen</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>99 DOA A PG Station Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>A. P. 2. x 2</i>	
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>Emile</i> Last <i>Gumb</i>		d. STREET ADDRESS <i>1</i>	
4. DATE OF DEATH Month <i>February</i> Day <i>8</i> Year <i>1957</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>26 January 34</i>
9. AGE (In years last birthday) <i>23</i> yrs.		IF UNDER 1 YEAR Months <i>23</i> Days <i>23</i>	IF UNDER 24 HRS. Hours <i>23</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Soldier</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Army</i>	11. BIRTHPLACE (State or foreign country) <i>Virgin Islands</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>		13. FATHER'S NAME <i>Unknown-Deceased 1941</i>	
14. MOTHER'S MAIDEN NAME <i>Ann Marie Leonie</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	
16. SOCIAL SECURITY NO. <i>580-01-0568</i>		17. INFORMANT Address <i>Official Army Records, A.P.G., Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Evisceration cerebrum</i> 802x DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fracture both bones both legs</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Hit by Penn RR train</i>		20c. TIME OF INJURY Month, Day, Year <i>5:50 a.m. 2-8 1957</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Penn RR tracks Abertdeen Harford Md</i>	
20f. (City or town) (County) (State) <i>Abertdeen Harford Md</i>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE <i>Gerald C Palmer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Harford</i>	
EXAMINER'S NAME (Type) <i>Gerald C Palmer</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>Bol Air, Md.</i>		DATE SIGNED <i>2-9-57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		22b. DATE THEREOF <i>Feb 14 1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Unknown</i>		22d. LOCATION (City, town, or county) (State) <i>Virgin Islands</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Barney abertdeen md.</i>		24a. REC'D BY REGISTRAR DATE <i>Feb. 13-57</i>	
24b. REGISTRAR'S SIGNATURE <i>Hellie R. Perry</i>			

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION & WELFARE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, date of birth, sex, race, and cause of death. The form is mostly blank with some faint, illegible markings.

BUREAU V. 2

1957

RECEIVED

John P. Corning
12-14-57
[Signature]

TO FURNISH TO THE REGISTRAR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FURNISH TO THE REGISTRAR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01864

1850

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>22 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hosp.</u>		d. STREET ADDRESS <u>Cal. 2</u>	
3. NAME OF DECEASED (Type or print) First <u>Trudy</u> Middle <u>alice</u> Last <u>Hanson</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>Girl</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/31/57</u>
9. AGE (In years last birthday) <u>22</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>HAROLD Eugene Hanson</u>		14. MOTHER'S MAIDEN NAME <u>Betty Alice Posey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital records - Harold Grace</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>560.4</u> DUE TO <u>Congenital evisceration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> DUE TO <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-31, 1957</u> to <u>2-22, 1957</u> , that I last saw the deceased alive on <u>2-22, 1957</u> , and that death occurred at <u>10:00 A.M.</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Harford Memorial Hosp</u> DATE SIGNED <u>2-22-57</u>	
ACTUAL SIGNATURE <u>Walfrido H. Hernandez</u> M.D.		PHYSICIAN'S NAME (Type) <u>Walfrido C. Fernandez</u> <u>Harford Memorial Hospital</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Rural</u>		22b. DATE THEREOF <u>2-24-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mountain View</u>		22d. LOCATION (City, town, or county) (State) <u>Sharon - Harford - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins - Delta, Penna.</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>2-22-57</u>	
ADDRESS <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>	

2071181XV2

CERTIFICATE OF DEATH

REG. DIV. 12A

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>MALE</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>FEB 23 1957</i>		5. TIME OF DEATH <i>10:15 AM</i>		6. PLACE OF DEATH <i>HOME</i>	
7. CAUSE OF DEATH <i>HEART DISEASE</i>		8. MANNER OF DEATH <i>NATURAL</i>		9. SIGNATURE OF PHYSICIAN <i>J. J. SMITH</i>	
10. SIGNATURE OF REGISTRAR <i>J. J. SMITH</i>		11. SIGNATURE OF WITNESS <i>J. J. SMITH</i>		12. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
13. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		14. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		15. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
16. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		17. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		18. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
19. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		20. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		21. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
22. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		23. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		24. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
25. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		26. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		27. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
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31. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		32. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		33. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
34. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		35. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		36. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
37. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		38. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		39. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
40. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		41. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		42. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
43. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		44. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		45. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
46. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		47. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		48. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
49. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		50. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		51. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
52. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		53. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		54. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
55. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		56. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		57. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
58. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		59. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		60. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
61. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		62. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		63. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
64. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		65. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		66. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
67. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		68. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		69. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
70. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		71. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		72. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
73. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		74. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		75. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
76. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		77. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		78. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
79. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		80. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		81. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
82. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		83. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		84. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
85. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		86. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		87. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
88. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		89. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		90. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
91. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		92. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		93. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
94. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		95. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		96. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
97. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		98. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		99. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	
100. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		101. SIGNATURE OF DECEASED <i>J. J. SMITH</i>		102. SIGNATURE OF DECEASED <i>J. J. SMITH</i>	

BUREAU V. 2

FEB 25 1957

RECEIVED

1
8

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01865

1851 **CERTIFICATE OF DEATH**

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u>		COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Forest Hill</u>		LENGTH OF STAY (in this place) <u>8 Years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Forest Hill, Md.</u>				STREET ADDRESS (If rural give location) <u>/</u>			
3. NAME OF DECEASED (Type or Print) <u>Oleita Reynolds Harward</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 22 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 16, 1872</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WARREN REYNOLDS</u>				14. MOTHER'S MAIDEN NAME <u>HARRIETTE ROSS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <input checked="" type="checkbox"/> Yes			16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT & ADDRESS <u>Charles A. Harward, Forest Hill, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A) <u>Hypostatic Pneumonia, terminating</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 da</u>	
ANTECEDENT CAUSE(S) DUE TO <u>Cerebral Thrombosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>Chr. Hypertensive Cardio-Vascular Disease</u>						<u>10 yrs</u>	
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 1927</u> , to <u>Feb. 22 1957</u> , that I last saw the deceased alive on <u>Feb. 21st 1957</u> , and that death occurred at <u>7:22p.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wileard P. Hudson M.D.</u>				DATE SIGNED <u>Forest Hill, Md. Feb. 23, 1957</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 25, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Centre Methodist</u>		LOCATION (City, town, or county) (State) <u>Forest Hill Harford Md</u>	
24. REC'D BY REGISTRAR DATE <u>2-25-57</u>		REGISTRAR'S SIGNATURE <u>Priscilla Lowwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Foster Belcher</u>			

CERTIFICATE OF DEATH

See the back

1. NAME OF DECEASED (Print or Write)

2. PLACE OF DEATH

3. SEX (Print or Write)

4. AGE (Print or Write)

5. DATE OF DEATH

6. TIME OF DEATH (Print or Write)

7. PLACE OF BIRTH

8. OCCUPATION (Print or Write)

9. CAUSE OF DEATH (Print or Write)

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEAREST RELATIVE

16. SIGNATURE OF CLERGYMAN

17. SIGNATURE OF JUDGE

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF CORONER

20. SIGNATURE OF JURY

21. SIGNATURE OF JUDGE

22. SIGNATURE OF SHERIFF

23. SIGNATURE OF CORONER

24. SIGNATURE OF JURY

25. SIGNATURE OF JUDGE

26. SIGNATURE OF SHERIFF

27. SIGNATURE OF CORONER

28. SIGNATURE OF JURY

29. SIGNATURE OF JUDGE

30. SIGNATURE OF SHERIFF

31. SIGNATURE OF CORONER

32. SIGNATURE OF JURY

33. SIGNATURE OF JUDGE

34. SIGNATURE OF SHERIFF

35. SIGNATURE OF CORONER

36. SIGNATURE OF JURY

37. SIGNATURE OF JUDGE

38. SIGNATURE OF SHERIFF

39. SIGNATURE OF CORONER

40. SIGNATURE OF JURY

41. SIGNATURE OF JUDGE

42. SIGNATURE OF SHERIFF

43. SIGNATURE OF CORONER

44. SIGNATURE OF JURY

45. SIGNATURE OF JUDGE

46. SIGNATURE OF SHERIFF

47. SIGNATURE OF CORONER

48. SIGNATURE OF JURY

49. SIGNATURE OF JUDGE

50. SIGNATURE OF SHERIFF

51. SIGNATURE OF CORONER

52. SIGNATURE OF JURY

53. SIGNATURE OF JUDGE

54. SIGNATURE OF SHERIFF

55. SIGNATURE OF CORONER

56. SIGNATURE OF JURY

57. SIGNATURE OF JUDGE

58. SIGNATURE OF SHERIFF

59. SIGNATURE OF CORONER

60. SIGNATURE OF JURY

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62. SIGNATURE OF SHERIFF

63. SIGNATURE OF CORONER

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73. SIGNATURE OF JUDGE

74. SIGNATURE OF SHERIFF

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79. SIGNATURE OF CORONER

80. SIGNATURE OF JURY

81. SIGNATURE OF JUDGE

82. SIGNATURE OF SHERIFF

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101. SIGNATURE OF JUDGE

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103. SIGNATURE OF CORONER

104. SIGNATURE OF JURY

105. SIGNATURE OF JUDGE

106. SIGNATURE OF SHERIFF

107. SIGNATURE OF CORONER

108. SIGNATURE OF JURY

109. SIGNATURE OF JUDGE

110. SIGNATURE OF SHERIFF

111. SIGNATURE OF CORONER

112. SIGNATURE OF JURY

113. SIGNATURE OF JUDGE

114. SIGNATURE OF SHERIFF

115. SIGNATURE OF CORONER

116. SIGNATURE OF JURY

117. SIGNATURE OF JUDGE

118. SIGNATURE OF SHERIFF

119. SIGNATURE OF CORONER

120. SIGNATURE OF JURY

121. SIGNATURE OF JUDGE

122. SIGNATURE OF SHERIFF

123. SIGNATURE OF CORONER

124. SIGNATURE OF JURY

125. SIGNATURE OF JUDGE

BUREAU V. 1

FEB 26 1957

RECEIVED

1

INSTRUCTIONS

TO A **ENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO **FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01866

CERTIFICATE OF DEATH

1852

Reg. Dist. No. 182

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Harford</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Harford</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <i>Earlington</i>		TOWN <i>Earlington</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
		<i>Rural</i>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<i>Fields, Hic Hash</i>		<i>Feb. 20, 1957</i>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<i>Male</i>	<i>White</i>	<i>Married</i>	<i>April 13, 1864-93</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Retired Farmer</i>		<i>Ord. Co. M. C. 75 A</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Sam H. Hash</i>		<i>Elizabeth Hawkins</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.)		16. SOCIAL SECURITY NO.	
<i>No</i>		<i>No</i>	
17. INFORMANT & ADDRESS			
<i>Mr Mrs Fields Hash</i>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<i>Earlington Md</i>	
IMMEDIATE CAUSE (A) <i>450.0</i>		<i>10 Days</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Bronchial Pneumonia</i>		<i>5 yrs</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Anterior Scleroma</i>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>infarctus of leg</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Feb 10, 1957</i> to <i>Feb 20, 1957</i> , that I last saw the deceased alive on <i>Feb 20, 1957</i> , and that death occurred at <i>9:40</i> M, from the causes and on the date stated above.			
SIGNATURE <i>F P Snodgrass</i>		DATE SIGNED <i>2/21/57</i>	
M.D.		ADDRESS (Street, city, town, state) <i>Baltimore Md</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		LOCATION (City, town, or county)	
<i>Feb 22, 1957 Removal to</i>		<i>Earlington Md</i>	
24. REG'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
REGISTRAR'S SIGNATURE <i>Earlington Md</i>		<i>Barley Earlington Md</i>	
DATE <i>Feb 24, 1957</i>			

CERTIFICATE OF DEATH

With Care, Two

BY MEDICAL EXAMINER OR SURGEON

NAME OF DECEASED
AGE
SEX
DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION

PLACE OF DEATH

DATE OF DEATH
HOUR
MINUTE
SECOND

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

OTHER

REMARKS

SIGNATURE OF MEDICAL EXAMINER

DATE

PLACE

STATE

COUNTY

CITY

ZIP CODE

REGISTRATION NO.

FILE NO.

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

STATE

COUNTY

CITY

PHOTOGRAPH

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS THE PROPERTY OF THE STATE OF MARYLAND. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTER OF DEATHS FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO ANY PERSON WHO REQUESTS IT. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTER OF DEATHS FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO ANY PERSON WHO REQUESTS IT.

BUREAU V. S.

MAR 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1853

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01867

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford Grace 20m</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New York City 69x-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>4650 W 111 St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John A. Johnson</u>		4. DATE OF DEATH Month Day Year <u>February 10 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 17, 1917</u>
9. AGE (In years last birthday) <u>39</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Post Office</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Alfonso Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Mabel Anderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>518-16-4901</u>	
17. INFORMANT <u>Catherine Johnson</u>		Address <u>4650 W 111 St N.Y.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of Skull</u> 819X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (a) _____ (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto - at grade type</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>Feb 9 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>NS Route 1</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bel Air Maryland</u>		20f. (City or town) (County) (State) <u>Bel Air Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 15, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>New York, N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles B. Lewis</u>		ADDRESS <u>1639 N. Broadway Baltimore</u>	
24a. REC'D BY REGISTRAR <u>Feb 13 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. L. Lewis</u>	

MEDICAL CERTIFICATION

12

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please extend the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

BUREAU V. S.

FEB 18 1957

RECEIVED

1854

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - PYLESVILLE				c. LENGTH OF STAY IN 1b 9 Mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 RURAL - PYLESVILLE			
				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last AMERICUS I. JONES				4. DATE OF DEATH Month Day Year FEB. 15, 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 4, 1881		9. AGE (In years and birthday) 75 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) QUARRY WORKER				10b. KIND OF BUSINESS OR INDUSTRY SLATE		11. BIRTHPLACE (State or foreign country) HARFORD CO., MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME HIRAM JONES				14. MOTHER'S MAIDEN NAME MARGARET WRIGHT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
				17. INFORMANT Address MRS. BESSIE F. JONES, PYLESVILLE, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) circulatory collapse 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) spontaneous pneumothorax DUE TO (c) probable pneumonia							INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from February 1, 1957 , to February 17, 1957 , that I last saw the deceased alive on February 17, 1957 , and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE BENJAMIN DOROGI, M.D.				ADDRESS (Street, city or town, state) Cardiff, Md.			
DATE SIGNED 2/18/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-18-57		22c. NAME OF CEMETERY OR CREMATORY SLATE RIDGE		22d. LOCATION (City, town, or county) (State) DELTA, PA.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Perkins, Delta, Pa.				24a. REC'D BY REGISTRAR DATE 2-19-57		24b. REGISTRAR'S SIGNATURE Bessie F. Jones	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

BUREAU V. 3

FEB 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1855

CERTIFICATE OF DEATH

Reg. Dist. No.

(01869)
01869

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITEFORD				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 WHITEFORD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last BERTHA ELIZABETH JONES				4. DATE OF DEATH Month Day Year FEB 19 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 29, 1882		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) HARFORD CO., MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME THOMAS HUGHES				14. MOTHER'S MAIDEN NAME JULIA MORRISON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 212-22-7943			
17. INFORMANT MARTORIE JONES, WHITEFORD, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive C-V Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 6 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1940 to Feb 19, 1957 , that I last saw the deceased alive on Feb 19, 1957 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Josiah A. Hunt M.D.				ADDRESS (Street, city or town, state) Delta Pa.			
DATE SIGNED 2/21/57							
PHYSICIAN'S NAME (Type) Josiah A. Hunt, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 2-22-57		22c. NAME OF CEMETERY OR CREMATORY SLATE RIDGE		22d. LOCATION (City, town, or county) (State) DELTA, PA.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harkins, Delta, Pa.				ADDRESS		24a. REC'D BY REGISTRAR DATE 2-22-57	
				24b. REGISTRAR'S SIGNATURE Prueella Howard			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
FEB 25 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1856

CERTIFICATE OF DEATH

Reg. Dist. No.

91870

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>STREET</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 STREET</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>E</u> Last <u>JONES</u>				4. DATE OF DEATH Month <u>FEB</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 1, 1861</u>		9. AGE (In years last birthday) <u>96</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>HARFORD CO. MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>WILLIAM LEONARD</u>				14. MOTHER'S MAIDEN NAME <u>LUCY HAYES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Bessie O'neal Street Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>381X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cerebrovascular disease</u> DUE TO (c) <u>10 yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Jan 15</u> , 1954, to <u>Feb 21</u> , 1957 that I last saw the deceased alive on <u>Sept 1</u> , 1957, and that death occurred at <u>3 A. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Charles A. Neff</u> M.D.				ADDRESS <u>Street, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Charles A. Neff M.D.</u>				ADDRESS <u>Street, Maryland.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-24-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ZION AVE</u>		22d. LOCATION (City, town, or county) (State) <u>FAUNTWP. YORK CO. PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Orshman</u>				ADDRESS <u>Stewartstown Pa.</u>		24a. REC'D BY REGISTRAR <u>DATE 2-23-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Phyllis Lowwood</u>			

FEB 25 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third-copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01871

1857 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Harford</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Harford</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Darlington</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Darlington</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <i>B. G. S. Dourdan</i> (Middle) (Last)		(Month) <i>Feb</i> (Day) <i>21</i> (Year) <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Dec 16, 1885</i>
9. AGE last birthday <i>71</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Armed Forces</i>	
11. BIRTHPLACE (State or foreign country) <i>Harford Co., Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>C. Reed Dourdan</i>		14. MOTHER'S MAIDEN NAME <i>Martina Hopkins</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-32-4023</i>	
17. INFORMANT'S ADDRESS <i>Mr Walter Dourdan</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <i>4221 CONGESTIVE HEART FAILURE</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerotic Cardio Vascular disease</i>		<i>8 yrs</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Bronchial Asthma</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>May 8, 1948</i> , to <i>Feb 21, 1957</i> , that I last saw the deceased alive on <i>2/20, 1957</i> , and that death occurred at <i>8:30 A.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Malcolm Dudley Phillips</i> M.D.		ADDRESS (Street, city, town, state) <i>Darlington, Md</i>	
DATE SIGNED <i>2/23/57</i>			
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>Feb 24, 1957</i>	
NAME OF CEMETERY OR CREMATORY <i>Darlington Cem</i>		LOCATION (City, town, or county) <i>Harford Co., Md</i>	
24. REC'D BY REGISTRAR <i>Feb 22, 1957</i>		REGISTRAR'S SIGNATURE <i>C. H. Kirby</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>H. S. Bailey</i>		ADDRESS <i>Darlington, Md</i>	

BUREAU V. 3

MAR 4 1957

RECEIVED

1

INSTRUCTIONS

TO A ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01872

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1858

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Forest Hill, Rural</u>		LENGTH OF STAY (in this place) <u>128 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Forest Hill, Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Irene</u>		(Middle) <u>Colgan</u>		(Last) <u>Lancaster</u>		(Month) <u>Feb.</u> (Day) <u>2</u> (Year) <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>7-30-86</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Fallston Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Colgan</u>				14. MOTHER'S MAIDEN NAME <u>Erene Bagley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>George E Lancaster Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Acute coronary occlusion</u>						6 1/2 hours	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis.</u>						Prob. 10 to 15 years.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Diabetes mellitus</u>						2 1/2 years	
260.3 (C) <u>Cholelithiasis</u>						Unknown	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED					
		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Sept. 29, 1954</u> , to <u>Feb. 2, 1957</u> , that I last saw the deceased alive on <u>Feb. 2, 1957</u> , and that death occurred at <u>11:50a</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>Robert Barth</u>				ADDRESS (Street, city, town, state) <u>Forest Hill, Maryland</u>		DATE SIGNED <u>2-2-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>FEB 5-57</u>		NAME OF CEMETERY OR CREMATORY <u>St. John's</u>		LOCATION (City, town, or county) (State) <u>Hyles Balto Co Md</u>	
24. REC'D BY REGISTRAR <u>2-5-57</u>		REGISTRAR'S SIGNATURE <u>Russell Lowwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Markus S. Kurfjanowski</u>		ADDRESS <u>—</u>	

A34

CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
PLACE OF BIRTH [REDACTED]		OCCUPATION [REDACTED]		MARITAL STATUS [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		MEDICAL OPINION [REDACTED]	
SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF PHYSICIAN [REDACTED]	
SIGNATURE OF CORONER [REDACTED]		SIGNATURE OF JURY [REDACTED]		SIGNATURE OF JUDGE [REDACTED]	

BUREAU V. 1

FEB 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01873

Reg. Dist. No.

185

1859

1. PLACE OF DEATH a. COUNTY Harford MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Del. b. COUNTY <input checked="" type="checkbox"/> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 46X-3 Newport d. STREET ADDRESS 803 Harwood Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Maynord Middle A. Last Lantis				4. DATE OF DEATH Month Feb. Day 14 Year 19 57															
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/25/1915		9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months 14 Days 14		IF UNDER 24 HRS. Hours 19 Min. 57							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN				10b. KIND OF BUSINESS OR INDUSTRY BUILDING SUPPLIES				11. BIRTHPLACE (State or foreign country) INDIANA				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME ORV C LANTIS						14. MOTHER'S MAIDEN NAME LENA HARSHMAN													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address MRS. MARY LANTIS 803 HARWOOD RD.													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive bilateral hemothorax due to crushing injury of chest 816X XXXX TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto-auto collision															
20c. TIME OF INJURY Month, Day, Year Hour XXXX p. m. 2/14/ 19 57				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street				20f. (City or town) (County) (State) Harford Md.									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																			
ACTUAL SIGNATURE 						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED 2/15/57							
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.						22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL								22b. DATE THEREOF 2/18/57		22c. NAME OF CEMETERY OR CREMATORY GRACE LAWN MEM.		22d. LOCATION (City, town, or county) (State) PK. NEWCASTLE Co. DEL.	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks														ADDRESS Elkton, Md.		23a. RECEIVED BY REGISTRAR FEB 18 1957		23b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the file of the deceased. Page 5 may be retained for 10 days. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Manner of Death		Occupation		Education	
Residence		Birthplace		Date of Birth	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Examination		Time of Examination		Place of Examination	
Signature of Physician		Signature of Nurse		Signature of Hospital	
Signature of Family		Signature of Friends		Signature of Community	
Signature of Church		Signature of School		Signature of Government	
Signature of Other		Signature of Other		Signature of Other	

BUREAU V. S.

FEB 18 1957

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01874

CERTIFICATE OF DEATH

1860

Reg. Dist. No. 187

1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> TOWN <u>all life</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> TOWN <u>Rural</u> STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) <u>Ellen</u> (Middle) <u>Elizabeth</u> (Last) <u>Livezey</u>				4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>15</u> (Year) <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Oct 7, 1871</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Harford Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>George T. Everiest</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Baker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs James Livezey</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
260X IMMEDIATE CAUSE (A) <u>CEREBRAL THROMBOSIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>CEREBRAL ARTERIOSCLEROSIS</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>DIABETES MELLITUS</u>				10 yr.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CARCINOMA LEFT BREAST</u>				2 yr.?			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 1</u> , 19 <u>45</u> , to <u>Feb. 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb. 13</u> , 19 <u>57</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u> M.D.				ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u>		DATE SIGNED <u>2-15-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb 18, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Zion Methodist</u>		LOCATION (City, town, or county) <u>Bel Air Md.</u>	
24. REC'D BY REGISTRAR <u>FEB 25 1957</u>		REGISTRAR'S SIGNATURE <u>Fusella Lowwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W.H. Archer</u>		ADDRESS <u>Benson Md.</u>	

CERTIFICATE OF DEATH

Form No. 100-1

LOCAL HEALTH DEPARTMENT OF BOSTON

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

US BIRTH

ALIEN BIRTH

IMMIGRATION

DEPORTATION

REENTRY

STATUS

RESIDENCE

DEATH CERTIFICATE

DEATH RECORD

DEATH INDEX

DEATH LIST

DEATH SUMMARY

DEATH ANALYSIS

DEATH TRENDS

DEATH PATTERNS

DEATH FACTORS

DEATH RISKS

DEATH PREVENTION

DEATH INTERVENTION

DEATH OUTCOMES

DEATH IMPACT

DEATH LEGACY

DEATH HERITAGE

DEATH IDENTITY

DEATH ESSENCE

DEATH CORE

DEATH CENTER

DEATH HEART

DEATH SPIRIT

DEATH SOUL

DEATH BODY

BUREAU OF HEALTH

FEB 25 1957

RECEIVED

1861

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Mary Cordelia McCommons</u>				4. DATE OF DEATH <u>Feb 27</u> 19 <u>57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 7-1866</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Wilmington Del</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew W. Banister</u>				14. MOTHER'S MAIDEN NAME <u>Eliza J. Grafton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs Jeanne Walker Forest Hill Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia (terminal)</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>Chr hypertensive cardio-vascular disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 da.</u> <u>2-23-57</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chr. osteoarthritis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 4</u> , 19 <u>55</u> , to <u>Feb. 27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb. 26</u> , 19 <u>57</u> , and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.				ADDRESS (Street, city or town, state) <u>Forest Hill Md.</u>		DATE SIGNED <u>2-27-57</u>	
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Deer Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Chesnut Hill Hartford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin A. Kurtz</u>				ADDRESS <u>Janetville Md</u>		24a. REC'D BY REGISTRAR DATE <u>3-4-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Praxilla Lowndes</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Holston

Forest Hill

Married

Married

Mary Cordelia Mc Carmon

Female White

X

Aug 7-1866

Married

Married

Charles W. Hamster

Eliza J. Hamster

No

John Hamster

BUREAU V. S.

MAR 6 1957

RECEIVED

Deer Park

Summit

1862

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R. F. NO. # 2</u>				d. STREET ADDRESS <u>1 R. F. NO. # 2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Olivia</u> Middle <u>P.</u> Last <u>McLain</u>				4. DATE OF DEATH Month <u>2</u> Day <u>27</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-23-1898</u>	
				9. AGE (In years lost birthday) <u>58</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Darlington, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Webster</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Webster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		(If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>213-16-1072</u>		17. INFORMANT <u>Mr. Agnes Wilson</u> Address <u>Street, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (b), (c), and (d).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO (b) <u>tro</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>r</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>v</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>v</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb 27, 1957</u> to <u>Feb 27, 1957</u> , that I last saw the deceased alive on <u>Feb 27, 1957</u> , and that death occurred at <u>5:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. P. Snodgrass</u> M.D.				ADDRESS (Street, city or town, state) <u>Darlington Md</u>			
DATE SIGNED <u>2/28/57</u>							
PHYSICIAN'S NAME (Type) <u>F. P. Snodgrass M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-3-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Clarks Chapel Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore-Harford Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Otelia J. Bullock-Harford Harford Co. Md.</u>				ADDRESS <u>Harford Co. Md.</u>		24a. REC'D BY REGISTRAR <u>Feb 27</u> DATE <u>2/27/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. W. Kirk</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 7 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01877

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>Harris</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford Grace</u>		c. LENGTH OF STAY IN 1b <u>none</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colora</u> <u>07X12</u> ✓
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Loretta</u> Middle <u>Miller</u> Last <u>Miller</u>		4. DATE OF DEATH Month <u>February</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 6, 1873</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>18</u>	IF UNDER 24 HRS. Hours <u>18</u> Min. <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Jake Miller</u>	
14. MOTHER'S MAIDEN NAME <u>Martha Tipton</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>Mrs Neal pate, Colora, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Cervical Vertebra</u> 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>900.0</u> (a), stating the underlying cause last. DUE TO (c) <u>900.0</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down stairs at her home</u>	
20c. TIME OF INJURY Month, Day, Year <u>Hour 7:30 p.m. 2-18-57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Colora Cecil</u> (County) <u>MD</u> (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Ronald P Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Ronald P Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <u>Hayford Co.</u>		DATE SIGNED <u>2-18-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-21-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>		22d. LOCATION (City, town, or county) <u>Port Deposit, Md.</u> (State) <u>Rural</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson & Son,</u>		ADDRESS <u>Perryville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 2-20-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

FEB 25 1957

RECEIVED

TO BE RETAINED BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG212 3-13-57 et

CERTIFICATE OF DEATH

01878

Reg. Dist. No.

185

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>2 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>318 Old Post Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type of print) <u>Hubert Atwood Morton</u>				4. DATE OF DEATH Month <u>2</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 21-1882</u>	9. AGE (In years lost birthday) <u>74</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rental Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rental Agent</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Morton</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Motley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>242-26-5914</u>		17. INFORMANT Address <u>Mrs Hubert Morton 318 Old Post Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Atherosclerosis</u> DUE TO <u>Arteriosclerosis</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>13 mos.</u> <u>yes.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1953</u> to <u>2/10</u> , 1957, that I last saw the deceased alive on <u>2/10</u> , 1957, and that death occurred at <u>6:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. J. Hatem</u>		M.D. <u>17 N. Phila. Blvd, Aberdeen, Md.</u>		ADDRESS (Street, city or town, state)		DATE SIGNED <u>2/10/57</u>	
PHYSICIAN'S NAME (Type) <u>F. J. Hatem</u>		ADDRESS <u>17 N. Phila Blvd. Aberdeen, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>2/12/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Albemarle N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Farreng</u>		ADDRESS <u>Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>2-14-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis mal</u>	

CERTIFICATE OF DEATH

Case No. 1057

X

72 5701-1012

1057

345 26-284 New Robert Jester 318 old 1057

1057

BUREAU V. 2

1057

RECEIVED

John F. Jester

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1865 **CERTIFICATE OF DEATH**

01879

Reg. Dist. No. 182

1. PLACE OF DEATH Fountain Green		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Harford	MARYLAND	STATE Md.	COUNTY Harford
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Rural -- Bel Air	LENGTH OF STAY (in this place) 30 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural-- Bel Air	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) Fountain Green, Route 2	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) CLIDE ALICE QUILLEN		4. DATE OF DEATH (Month) (Day) (Year) February 25 1957	
5. SEX Fem.	6. COLOR OR RACE Wh	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Wid.	8. DATE OF BIRTH April 13, 1884
9. AGE last birthday 72 yrs.		10. IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Grayson Co., Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME H. K. McGrady		14. MOTHER'S MAIDEN NAME Rebecca Goings	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-24-4960	
17. INFORMANT & ADDRESS Guy Quillen, Bel Air, Md.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			15 MIN.
420.1 IMMEDIATE CAUSE (A) CORONARY OCCLUSION			
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO			
(C) Chr. Hypertensive Cardio-vascular disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Acute Viral gastro-enteritis			10, da.
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. HOW DID INJURY OCCUR?	
21f. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			
22. I hereby certify that I attended the deceased from June 1932, 19, to Feb. 25, 1957....., that I last saw the deceased alive on Feb. 20, 1957, and that death occurred at 1:30 PM , from the causes and on the date stated above.			
SIGNATURE Willard P. Hudson M.D.		ADDRESS (Street, city, town, state) Forest Hill, Md.	
DATE SIGNED 2-26-57		DATE SIGNED 2-26-57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. DATE OF BURIAL Feb. 27, 1957	
25. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		26. LOCATION (City, town, or county) (State) Harford County Md	
27. REC'D BY REGISTRAR Priscilla Foxwood		28. REGISTRAR'S SIGNATURE Joseph W. Foster, Bel Air, Md.	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1957

BUREAU V. 5

FEB 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01880

1865

CERTIFICATE OF DEATH

Reg. Dist. No.

187

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beldin - R.F.D.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 3v01-4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Conv. Home</u>				d. STREET ADDRESS <u>938 Cator Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Miss Essie C.</u> Middle <u>(Roach)</u> Last <u>Roche</u>				4. DATE OF DEATH Month <u>February</u> Day <u>19</u> Year <u>19 57</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 11, 1879</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired School Teacher</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Roche (Roach)</u>				14. MOTHER'S MAIDEN NAME <u>Mary Harding</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT Address <u>Mrs. Joseph Billingslea, Baldwin, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chr. Cardio-vascular Disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>15 min. ?</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 18</u> , 19 <u>57</u> , to <u>Feb. 19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb. 18</u> , 19 <u>57</u> , and that death occurred at <u>9:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.				ADDRESS (Street, city or town, state) <u>Forest Hill, Md.</u> DATE SIGNED <u>2-20-57</u>			
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/22/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Maria Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Leonard J. Ruck 5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 21 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Priscilla Townsend</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01881

1867 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Joppa				c. LENGTH OF STAY IN 1b 11 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 2-A, RFD #1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PAUL Middle (nmi) Last ROSS				4. DATE OF DEATH Month February Day 15 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 14, 1884		9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Reason Ross				14. MOTHER'S MAIDEN NAME Mary (?)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT William Powers, Jr.; Box 2-A, RD #1, Joppa, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary congestion 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) Congestive heart failure DUE TO (c) Arteriosclerotic cardiovascular disease						INTERVAL BETWEEN ONSET AND DEATH several hrs. 6 months several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Bel Air, Md.		(County) (State)	
21. I certify that I attended the deceased from January 26, 1957 , to February 15, 1957 , that I last saw the deceased alive on February 15, 1957 , and that death occurred at 9:55 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 115 Fulford Ave., Bel Air, Md. DATE SIGNED 2/15/57							
ACTUAL SIGNATURE Paul S. Stonesifer, Jr. M.D.				DATE SIGNED 2/15/57			
PHYSICIAN'S NAME (Type) Paul S. Stonesifer, Jr.				ADDRESS Bel Air, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 18, 1957		22c. NAME OF CEMETERY OR CREMATORY Spesutia		22d. LOCATION (City, town, or county) (State) Perryman, Harford, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McNamee & Son				ADDRESS Abingdon Md.		24a. REC'D BY REGISTRAR Feb 18, 1957	
						24b. REGISTRAR'S SIGNATURE Norma E. Moore	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
SEX		AGE		OCCUPATION	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS	
DATE		PLACE		CITY	
COUNTY		STATE		ZIP CODE	
FEDERAL BUREAU OF INVESTIGATION		U.S. DEPARTMENT OF JUSTICE		WASHINGTON, D.C.	

BUREAU V. B.

FEB 20 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

18

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bell Air</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Aberdeen Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Harford Convalescing Home</u>		d. STREET ADDRESS <u>Near Osborns Packing factory</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George - Savage</u>		4. DATE OF DEATH Month Day Year <u>February 8 19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>(Unknown)</u>	8. DATE OF BIRTH <u>1884</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Packing factory</u>	11. BIRTHPLACE (State or foreign country) <u>Russia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>	
16. SOCIAL SECURITY NO. <u>219-07-5816</u>		17. INFORMANT Address <u>Phas Osborn and Sons Aberdeen Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Stomach with wide metastases</u> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>56</u> to <u>Feb 8</u> , 19 <u>57</u> that I last saw the deceased alive on <u>Feb 2</u> , 19 <u>57</u> , and that death occurred at <u>84</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		DATE SIGNED <u>3 4 in Md. 2-8-57</u>	
PHYSICIAN'S NAME (Type) <u>Gerald C Palmer M.D.</u>			
22a. BURIAL-CREMATATION-REMOVAL (Specify)	22b. DATE THEREOF <u>Feb. 9/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>C. of Md. Med. School</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Barling Aberdeen Maryland</u>		24a. REC'D BY REGISTRAR <u>Priscilla Howard</u> DATE <u>FEB 13 1957</u>	

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name: *John William*
 Sex: *Male*
 Date of Birth: *1914*
 Place of Birth: *Johns Hopkins*
 Date of Death: *1957*
 Cause of Death: *Heart Disease*
 Physician: *Johns Hopkins*
 Burial Place: *Johns Hopkins*
 Signature: *Johns Hopkins*

Name: *John William*
 Sex: *Male*
 Date of Birth: *1914*
 Place of Birth: *Johns Hopkins*
 Date of Death: *1957*
 Cause of Death: *Heart Disease*
 Physician: *Johns Hopkins*
 Burial Place: *Johns Hopkins*
 Signature: *Johns Hopkins*

BUREAU V. 21

1957

RECEIVED

Johns Hopkins

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1869 CERTIFICATE OF DEATH

01883

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harrod Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Post Klfadit 07x02</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>90 N. Main St.</u>	
3. NAME OF DECEASED (Type or print) <u>Dora May</u> First Middle Last <u>Smith</u>		4. DATE OF DEATH Month <u>February</u> Day <u>26</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1876</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY	
11c. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Culberson</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Grey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>William M. Smith, 90 N. Main St. Md.</u>		Address <u>Port Depos</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease with</u> <u>422.1</u> DUE TO <u>Decompensation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypostatic pneumonitis; 1st + 2nd degree burns, legs</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part K of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb. 19, 1957</u> , to <u>Feb. 26, 1957</u> , that I last saw the deceased alive on <u>Feb. 26, 1957</u> , and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walfrido G. Fernandez</u> M.D.		ADDRESS (Street, city or town, state) <u>560 Harford Memorial Hosp</u> DATE SIGNED <u>2-26-57</u>	
PHYSICIAN'S NAME (Type) <u>Walfrido G. Fernandez M.D.</u>		<u>HARFORD MEMORIAL HOSP.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>3-1-1957</u>	<u>Oakwood Cemetery</u>	<u>Conowingo, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson & Son</u>		ADDRESS <u>Perryville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>3-1-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>	

CERTIFICATE OF DEATH

PLACE OF DEATH HOME		MARRIAGE NONE	
DATE OF DEATH 1957		PLACE OF BIRTH HOME	
NAME OF DECEASED JOHN DOE		SEX MALE	
AGE 45		RACE WHITE	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE	
PLACE OF DEATH HOME		MARRIAGE NONE	
DATE OF DEATH 1957		PLACE OF BIRTH HOME	
NAME OF DECEASED JOHN DOE		SEX MALE	
AGE 45		RACE WHITE	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE	

BUREAU V. S.

MAR 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01884

1870

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u> Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARREBE GRACE</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Memorial Hospital</u> <u>Charlestown</u> 07X22			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>see birth cert.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elyuthia Marie Shelley</u>				4. DATE OF DEATH Month <u>February</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-31-57</u>	
9. AGE (In years last birthday) yrs. <u>7</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min. <u>7</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Paul Richard Shelley</u>				14. MOTHER'S MAIDEN NAME <u>Marie Bertha Atkinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>R.P. Shelley, Charlestown, Md</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ateliotosis</u> DUE TO (c) <u>Bacterial Pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/31/57</u> , 19 <u>57</u> , to <u>2-7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 7</u> , 19 <u>57</u> , and that death occurred at <u>928</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. H. Richards Jr.</u>				M.D. <u>Port dePOSIT, Md</u> DATE SIGNED <u>2-7-1957</u>			
PHYSICIAN'S NAME (Type) <u>G. H. Richards Jr. M D</u>				<u>Port dePOSIT - Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2-8-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham</u>		22d. LOCATION (City, town, or county) (State) <u>Coloma, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Veeva Patterson & Son, Perryville, Md</u>				24a. REC'D BY REGISTRAR DATE <u>2-7-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M D</u>	

2071221XY2

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

BUREAU V. S.

FEB 11 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>H&Sord</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>H&Sord</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>		c. LENGTH OF STAY IN lb <u>64 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>	
		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Thomas Edward Stifler</u> First Middle Last		4. DATE OF DEATH <u>February 14 1957</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 29 1895</u> 6 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail</u>	11. BIRTHPLACE (State or foreign country) <u>MD</u>
13. FATHER'S NAME <u>George Edward Stifler</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Oliver</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-32-4114</u>	
		17. INFORMANT <u>Lara P. Stifler</u> Address <u>Fallston Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>H&Sord</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>County</u>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 14 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Goodwill</u>	22d. LOCATION (City, town, or county) (State) <u>Rutledge Harbor Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin Skutty</u>		ADDRESS <u>Carrollwood 72nd</u>	
		24a. REC'D BY REGISTRAR <u>2-11-57</u>	24b. REGISTRAR'S SIGNATURE <u>Priscilla Forward</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

FEB 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1872

CERTIFICATE OF DEATH

Reg. Dist. No.

01886

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. LENGTH OF STAY IN 1b <u>1 Day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Old Federal Hill Road Rockers Rd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>			d. STREET ADDRESS <u>Old Federal Hill Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Grace</u> Last <u>Letton</u>			4. DATE OF DEATH Month <u>February</u> Day <u>18</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 25 1912</u>		9. AGE (In years last birthday) <u>44</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Chestertown</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John Grubb</u>			14. MOTHER'S MAIDEN NAME <u>Augusta Adams</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Dallas F. Letton</u> Address <u>Rockers RD Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 224X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pheochromocytoma</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>about 6 hrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>2/17th</u> , 19 <u>57</u> to <u>2/18th</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/18th</u> , 19 <u>57</u> , and that death occurred at <u>11 P.M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Edward C. Loo</u> M.D. <u>211 N. Union Ave.</u>			ADDRESS (Street, city or town, state) <u>Harford Md.</u> DATE SIGNED <u>2/18/57</u>		
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u> <u>Harford Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>FEB 22-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LAWN CROFT</u>		22d. LOCATION (City, town, or county) (State) <u>LINWOOD PA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin Skutz</u> ADDRESS <u>Janettsville Md</u>			24a. REC'D BY REGISTRAR DATE <u>2-20-57</u>	24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1255

DATE OF DEATH

1957

X

X

1124

James F. Little, Jr. 85 M.

No

BUREAU V. 1

FEB 25 1957

RECEIVED

1-11-57

1-11-57

1-11-57

1873

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harris</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x1 Reckord Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rocks</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>August</u> Middle <u>E</u> Last <u>W. H. Hous</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 19, 1888</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Civil Service</u>	
11. BIRTHPLACE (State or foreign country) <u>Granite Balto Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Philip Dietz</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor J. Haversing</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WORLD WAR I</u>		16. SOCIAL SECURITY NO. <u>220-20-7615</u>	
17. INFORMANT <u>Clara Dietz</u>		Address <u>Hyde 12nd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>260X</u> (b) <u>Arterio Sclerotic Cardiovascular Disease</u> DUE TO <u>with congestive Heart Failure</u> (c) <u>INSTANT</u>			INTERVAL BETWEEN ONSET AND DEATH <u>over 10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus, Prostatic Adeno Carcinoma</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 18</u> , 19 <u>56</u> , to <u>Feb 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 4</u> , 19 <u>57</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip W. Hedman</u> M.D.		ADDRESS (Street, city or town, state) <u>307 Reckord Ave, Bel Air, Md</u> DATE SIGNED <u>Feb 13, 57</u>	
PHYSICIAN'S NAME (Type) <u>PHILIP W. HEDMAN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Feb 14/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Johns Episcopal</u>	22d. LOCATION (City, town, or county) (State) <u>Kingsville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Lister, Bel Air Md</u> ADDRESS		24a. REC'D BY REGISTRAR <u>2-13-57</u>	24b. REGISTRAR'S SIGNATURE <u>P. Weills Howard</u>

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1874

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - WHITEFORD		c. LENGTH OF STAY IN 1b 45 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN LEWIS WALKER		4. DATE OF DEATH Month FEB. Day 5 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 16, 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY AGRI.	9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) YORK CO., PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MAURICE WALKER		14. MOTHER'S MAIDEN NAME ELLA McCANDLESS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. OLITA B. WALKER, WHITEFORD RD. MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cerebro-vascular disease 1 wk DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 12, 1953 to Feb. 5, 1957 , that I last saw the deceased alive on Feb. 5, 1957 , and that death occurred at 11:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Street, Maryland DATE SIGNED 2-7-57 ACTUAL SIGNATURE Charles A. Neeff M.D. PHYSICIAN'S NAME (Type) CHARLES A. NEEFF MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2-8-57	22c. NAME OF CEMETERY OR CREMATORY TABERNACLE	22d. LOCATION (City, town, or county) (State) WHITEFORD RD., MD.
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harkins, Delta, Pa.		24a. REC'D BY REGISTRAR DATE 2-9-57	24b. REGISTRAR'S SIGNATURE Prueilla Lowwood

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED MARYLAND JAMES M. WATSON</p>		<p>2. SEX Male</p>	
<p>3. AGE 45</p>		<p>4. DATE OF DEATH Feb 13 1957</p>	
<p>5. PLACE OF DEATH Baltimore, Md.</p>		<p>6. CAUSE OF DEATH Myocardial Infarction</p>	
<p>7. PLACE OF BIRTH Baltimore, Md.</p>		<p>8. OCCUPATION Salesman</p>	
<p>9. MARITAL STATUS Married</p>		<p>10. EDUCATION High School</p>	
<p>11. RELIGION Catholic</p>		<p>12. SIGNATURE OF DECEASED (Signature)</p>	
<p>13. SIGNATURE OF WITNESS (Signature)</p>		<p>14. SIGNATURE OF PHYSICIAN (Signature)</p>	
<p>15. SIGNATURE OF CORONER (Signature)</p>		<p>16. SIGNATURE OF REGISTRAR (Signature)</p>	

BUREAU V. S.

FEB 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG211 2-25-57 et

01889

1875

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>Maryland</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> <u>24</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>none</u>				d. STREET ADDRESS <u>744 Fountain</u>			
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>Franklin</u> Last <u>Walker</u>				4. DATE OF DEATH Month <u>3</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/29/1891</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painting</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Andrew Walker</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Shank</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs. Ethel M. Nameth, Harford, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line (or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Mandible</u> <u>196X</u> DUE TO (b) <u>General Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Cachexia</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1957</u> to <u>Feb. 10, 1957</u> , that I last saw the deceased alive on <u>Feb. 10, 1957</u> , and that death occurred at <u>4:00 M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles J. Foley</u> M.D.				ADDRESS (Street, city or town, state) <u>400 S. Main Ave. Harford, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Charles J. Foley</u>				DATE SIGNED <u>2-12-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/12/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Harford, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James P. Per, Harford, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>2-12-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Davis, Md.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 14 1957



1876

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - STREET</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 RURAL - STREET</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JEANNETTE ELIZABETH WALLACE</u>		4. DATE OF DEATH Month Day Year <u>FEB. 20, 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 3, 1876</u>
9. AGE (In years last birthday) yrs. <u>80</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>HARFORD CO., MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS W. HEAPS</u>		14. MOTHER'S MAIDEN NAME <u>RACHAEL A. SCARBOROUGH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>THOMAS H. WALLACE, STREET, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>10 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden death</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 29, 1956</u> to <u>Feb. 20, 1957</u> , that I last saw the deceased alive on <u>Feb. 16, 1957</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles R. Gaff</u> M.D.		ADDRESS (Street, city or town, state) <u>Street, Md.</u> DATE SIGNED <u>2-22-57</u>	
PHYSICIAN'S NAME (Type) <u>Charles A. Noff MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2-23-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SLATE RIDGE</u>	22d. LOCATION (City, town, or county) (State) <u>DELTA, PA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins</u>		ADDRESS <u>Delta, Pa.</u>	24a. REC'D BY REGISTRAR DATE <u>2-22-57</u>
		24b. REGISTRAR'S SIGNATURE <u>Priscilla Lowood</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

[Faint, mostly illegible text from the reverse side of the document is visible through the paper. Discernible words include "MAY 1957", "Baltimore", "Maryland", "Certificate of Death", "Cause of Death", "Place of Death", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Time of Death", "Signature", "Official Use", "Filing Date", "Filing Office", "Filing Number", "Filing Date", "Filing Office", "Filing Number".]

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BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG211 2-25-57 et

1877

CERTIFICATE OF DEATH

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Reg. Dist. No. 182.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Bel Air</u>	
c. LENGTH OF STAY IN 1b <u>6 years</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford County Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>Williams</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>February</u> Day <u>18</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 18, 1881</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland "Bel Air"</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Washington Williams</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Anderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	
17. INFORMANT <u>Wm Anderson</u> <u>449 Chestnut Court Baltimore 22 Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) <u>Chronic Hypertensive Cardio-vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 6</u> , 19 <u>51</u> , to <u>Feb. 18</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb. 17</u> , 19 <u>57</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>2/18/57</u>			
ACTUAL SIGNATURE <u>Willard P Hudson</u> M.D.		PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u> <u>Forest Hill, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 21 / 57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hudson Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air MD</u> <u>4md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Lister</u>		24a. REC'D BY REGISTRAR DATE <u>2-19-57</u>	
ADDRESS <u>Bel Air md</u>		24b. REGISTRAR'S SIGNATURE <u>Priscilla Frouard</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

FEB 21 1957

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